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THE CHILD'S CONCEPTION OF
CONFIDENTIALITY IN THE PSYCHOTHERAPEUTIC RELATIONSHIP

BY

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B.A., University of South Florida, 1976

THESIS

Submitted in partial fulfillment of the
requirements for the degree of Master of Science:
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ABSTRACT

Children between the ages of 6 and 15 years were interviewed using a questionnaire designed to assess their conception of confidentiality in the counseling experience. This questionnaire was based upon the stipulates for confidentiality outlined in the 1977 American Psychological Association's Code of Ethics.

Children age 6 to 8 years scored significantly lower on the questionnaire than children age 12 to 15 years. Neither of these groups' scores were significantly different from the scores of children age 9 to 11 years, yet the total mean scores increased as the age of the children in the groups increased. These results suggest that children gradually evolve a conception of confidentiality consistent with professional guidelines.

Four variables were examined which were expected to grossly predict the child's total score on the questionnaire. Chi-square analysis did not reveal significant differences for the variables of perceived adequacy of explanation of confidentiality and attitude toward breaking a secret. For the two variables involving the children's perception of the maintenance/violation of their confidentiality, chi-square analysis did reveal

significant differences (which were not, however, found using a one-way analysis of variance procedure). Some demographic variables were found to be significantly related to scores on the questionnaire, yet most of the relationships involved specific area scores rather than total scores.

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INTRODUCTION

The responsibility to protect child-clients' privacy and maintain the confidentiality of their communications has increasingly concerned psychologists functioning in both public and private situations. Confidentiality is one of the most fundamental elements in the relationship between the client and psychologist, yet maintaining appropriate confidentiality of information received in psychotherapy is a complex problem for the psychologist. Effective psychotherapy depends largely on the disclosure of highly private information and feelings; the client usually assumes that his disclosures will not be passed to others without his knowledge and consent. In reality, however, confidentiality has both legal and ethical limitations.

Before examining confidentiality with the child in psychotherapy, it is necessary to explore various aspects of confidentiality. It has generally been understood that confidentiality refers to intimacy or privacy of communication. Trachtman (1972) has identified four levels of confidentiality:

1. The most general aspect of having faith and trust in another when communicating personal information;

2. the codes and norms of group members, particularly professionals such as psychologists;
3. the legal issue of privileged communication; and
4. the status of school records.

The first identified level of confidentiality can be considered a familiar, even routine, occurrence. The remaining three levels need to be explored more thoroughly in the perspective of the psychotherapeutic relationship.

Confidentiality at the professional level refers to the ethical standards of the psychologist or other professional not to reveal private communications from a client to others except under certain circumstances.

The American Psychological Association's (1977) Code of Ethics, Principle 5, Confidentiality, states that:

Safeguarding information about an individual that has been obtained by the psychologist in the course of his teaching, practice, or investigation is a primary obligation of the psychologist.

The code further states that information revealed in confidence is revealed only when the client gives his express permission or when there is clear, imminent danger to society or an individual (and then only to appropriate professional workers). The psychologist is responsible for informing his client of the limits of the

confidentiality.

The American Personnel and Guidance Association also clearly supports the practice of maintaining confidentiality. Sections B2 and B5 of the APGA's Ethical Standards stipulate:

The counseling relationship and information resulting therefrom must be kept confidential, consistent with the obligations of the member as a professional person Records of the counseling relationship including interview notes, test data, correspondence, tape recordings, and other documents are to be considered professional information for use in counseling, and they are not part of the public or official records of the institution or agency in which the counselor is employed. (APGA, 1974, p. 491)

As students are often counseled in the school setting, it should be noted that the National Education Association (1975-76) Code of Ethics also emphasizes professional responsibility to honor and protect confidences. Principle 1, Commitment to the Student, reads, in part, that the educator, "shall not disclose information about students obtained in the course of professional service, unless disclosure serves a compelling professional purpose or is required by law" (NEA, 1975-76, p. 235). Likewise, the National Association of School Psychologists (1976) has established guidelines for professional relationships in relation to confidentiality. Principle IIIb of its ethical code emphasizes the school psychologist's responsibility to explain to students the

uses to be made of information obtained and any obligation the psychologist has for reporting specific information. Principle Vd points out the psychologist's responsibility to "safeguard the personal and confidential interests of those concerned" (NASP, 1976, p. 103).

Another professional organization which has attempted to specify, although in only the broadest of terms, a provision for guarding the confidential communication of clients in its Code of Ethics is the National Association of Social Workers (1967). The code stipulates: "I respect the privacy of the people I serve" and "I use in a responsible manner information gained in professional relationships." Similarly, the American Psychiatric Association, the American Hospital Association, and the Group for the Advancement of Psychiatry have been actively studying issues of confidentiality and its maintenance (Reynolds, 1976).

The ethical standards of these various organizations show that a relationship of confidence and trust is essential to psychotherapeutic treatment. Judge Alverson of the Supreme Court of Atlanta has stated that: "Psychotherapy, by its very nature, is worthless unless the patient feels from the outset that whatever he may say will be forever kept confidential" (Reynolds, 1976, p. 109).

Confidentiality is basic not only to the therapeutic process, but to the very image of psychotherapists in society as well. Because of this, violations of the client's professional confidences outside the courtroom may give rise to several possible consequences. Shah (1969b) writes that a psychologist who gives unauthorized disclosures could face disciplinary action and professional sanctions by the American Psychological Association or by the state certifying or licensing authority (in relation to the psychologist's certificate or license). Furthermore, the psychologist might be faced with legal action and could be sued in a civil action if some damage to the client results or if the breach of confidence could be construed as a defamatory statement.

The third aspect of confidentiality is privileged communication, which refers to the legal rights of the client that protect him from having his confidences revealed publicly from the witness stand during legal proceedings without his permission (Shah, 1969). Where this legal testimonial privilege exists, the client is protected from the possibility that private information will be used as testimony in judicial proceedings. Most frequently, the purpose of privileged communication is to encourage confidential communication essential to effective treatment and to prevent unwarranted

humiliation from courtroom exposure of intimate information (Davis, 1971).

Some authors, however, have brought up the possible conflict between the citizen's right to privacy and society's right to proper administration of justice (Arnold, 1970; Dubey, 1974; Schmidt, 1962; Shah, 1969a; McDermott, 1972). Hollender (cited in Dubey, 1974) goes so far as to divide psychotherapy into two categories: patient-oriented and society-oriented. In the latter case, the therapist is "more or less the agent of people or agencies other than the patient" (p. 1094). The therapist does not necessarily promise confidence in such a setting but may instead deliberately use the client's information to exert power in influencing the patient's social milieu.

J. H. Wigmore (1961) has recommended four criteria for the validity of a privileged communication:

1. The communications must originate in a confidence that they will not be disclosed (Because a communication is made in an expressed or implied confidence does not necessarily allow it privilege, however [Schmidt, 1962].);
2. the element of confidentiality must be essential to the full and satisfactory maintenance of the relationship;
3. the relation must be one which in the opinion of the community ought to be sedulously fostered; and

4. the injury that would inure to the relation by the disclosure of the communication must be greater than the benefit thereby gained for the correct disposal of litigation.

The key words and phrases apparently qualify psychotherapeutic consultations for the protection offered by this privilege. Moreover, psychologists have some legal leeway in that they are under no obligation to reveal information considered confidential unless under oath or before a grand jury or court of law (Wrenn, 1952).

Goldstein and Katz (1962) have stated that

treatment of the mentally ill is too important and the assurance of confidentiality too central to it, to risk jeopardizing the whole because of the relevance of some patients' statements to some legal proceedings. (p. 735)

Legal testimonial privilege is not assured to clients of psychologists, however, and some states have no privileged communication statutes for clients of psychologists. As of May 1975, thirty-eight states plus the District of Columbia had legal privileged communication protection (APA, 1975, pp. 34-36).^{*} The California Supreme Court, while endorsing the principle of psychotherapist/patient privilege concluded

^{*}The following states had no privileged communication protection: Hawaii, Iowa, Massachusetts, North Dakota, Rhode Island, South Carolina, Texas, West Virginia and Wisconsin. The states of Missouri, South Dakota and Vermont had nonstatutory regulation of psychologists and thus presumably also lacked legal testimonial privilege for clients of psychologists.

that absolute confidentiality was not needed to protect the [psychotherapeutic] relationship and that the judge could determine what confidential information has to be disclosed to ensure the carrying out of justice (Plaut, 1974, p. 1023).

Likewise, Hollender (cited in Dubey, 1974), believes that many of the diverse operations of psychotherapy do not require confidentiality at all.

One specific aspect of privileged communication in the psychotherapeutic relationship concerns pupil-clients and school counselors. A study by Frerqueron (1974) examined the school counselor's ability to justify a need for statutory protection of privileged communication of their minor-clients. The main arguments supporting privileged communication for school counselors were that: students would be reluctant to seek the school counselors' services if they feared their communications would be disclosed; the counselor needs the ability to guarantee confidentiality in order to function in his professional role; Wigmore's criteria for privileged communication is satisfied by the counseling relationship; and the very nature of the counseling relationship necessitates the assurance of confidentiality. Further arguments were cited in comparing the school counseling relationship to established privileged professional relationships (i.e., attorney/client, physician/patient, and psychologist/client). Arguments opposing privileged

communication were: the school counselor lacks professional standards; privileged communication acts as an obstruction to justice and also restricts the counselor's ability to consult with other individuals; and a strong code of ethics is better protection than legislation.

The fourth level of confidentiality concerns students' school records. A number of controversies are salient in this area: the right of outside agencies to have access to the records; the availability of records to various personnel within the school; and the right of parents to inspect the records of their children. This last area of confidentiality represents a unique situation since parents are acting on behalf of an individual who is a minor.

There have been two notable attempts to protect the rights and privacy of students in recent years. In 1971, the National Education Association, which has traditionally argued for comprehensive record keeping, approved a code of students' rights and responsibilities (Burcky & Childers, 1976). According to this act, students' interests supersede all other interests for record-keeping purposes.

In 1974, federal legislative action--the Buckley Amendment, Public Law 93.380--became effective. This act requires that eligible students (generally defined as

eighteen years of age or older) or the parents of students have the right of access to all official files, records and data concerning their children (Education Amendments, 1974).

McGuire and Borowy (1978) have focused on the question of whether records in guidance offices, counseling centers and diagnostic or evaluative service centers are applicable. Typically, the statute is interpreted to mean that the counselor's records are confidential and do not become part of the student's cumulative record (Cutler, 1975), yet some university officials interpret the Buckley Amendment to mean that counseling records of students ought to be made available at least on a conditional basis (Kazalunas, 1977).

Perhaps more basic than the status of files is the question of whether the Buckley Amendment violates the ethics of confidentiality in the counseling relationship. The APA Code of Ethics, Principle 5, Section B, states that "information obtained in clinical or consulting relationships . . . are discussed only for professional purposes and only with persons clearly concerned with the case" (APA, 1963). Kazalunas (1977) believes that revealing confidences is now made possible by an act which was intended to protect students' interests, particularly their privacy. McGuire and Borowy, however, have

discussed the pertinent literature and have concluded that "the Buckley Amendment may be interpreted as being consistent with established ethical and legal practices of protecting the privacy of professional counseling records" (p. ii). They did note, though, that the decision of whether to release professional communications to a counselee or student should be based on the purposes for which the material was obtained (e.g., for personal counseling versus degree-program requirements).

The other side of confidentiality of school records concerns releasing information to school personnel and outside sources. Miller (1971) stresses the importance of safeguarding test data in particular against improper dissemination. He points out that the threat of information misuse may be exaggerated with test data because of "the illusion of 'hardness' created by numerical test scores or percentile ratings" (p. 94). Kaplan (1974) writes that the ethical duty to protect the confidences of pupil-clients would force counselors to deny some requests of teachers. He suggests counselors explain their feelings concerning ethical behavior, especially confidentiality, in a nonthreatening manner, personally and directly to the staff. Slovenko (1966) takes a similar, though somewhat stronger, position, stating that it is not the responsibility of teachers to delve into a

pupil's emotional problems and that pupils "are not patients in relation to the teacher while they are being taught" (p. 66).

Friedenberg (1964) examines the effect on the students' inner life and emotional dynamics when confidences are revealed to outside sources:

By permitting agencies outside the student-counselor relationship to use its records, the school strikes at the very roots of clarity and growth. It invades the unconscious . . . throwing up barriers of anxiety against self understanding . . . that it has made it dangerous for the student to deal honestly with himself is alarming. (p. 59)

Nonetheless, Boyd, Tennyson and Erickson (1973) have found that, in practice, complete confidentiality is rarely, if ever, extended to school-age clients. A study by these authors revealed that while counselors were more prone to deny requests for personal interview data than general education-vocational information, there was considerable individual variability in the extent of release of student records. Moreover, "school personnel receive more exact data about individual students than do parents or the students themselves" (p. 285).

The foregoing considerations of confidentiality with respect to professional ethics, legal issues, and school records have provided a basis with which to explore a most vital question of confidentiality: What is the status of the child-client in the clinical

psychotherapeutic relationship?

The APA Code of Ethics (1977), Principle 5, discusses confidentiality with particular emphasis on the obligation of the psychologist to safeguard information obtained about an individual in the course of the psychological practice. Nowhere, however, does Principle 5 clearly differentiate between the psychologist's ethical responsibility to the child-client versus an adult client. Section B of this principle stipulates that:

Information obtained in clinical or consulting relationships, or evaluative data concerning children . . . are discussed only for professional purposes and only with persons clearly connected with the case.

Ambiguity arises here over whether "persons clearly connected with the case" includes parents of minor-clients and whether "professional purposes" includes sharing communications with parents in the case of minor-clients.

Section D of this principle states that:

The confidentiality of professional communications about individuals is maintained. Only when the originator and other persons involved give their express permission is a confidential communication shown to the individual concerned.

The vagueness of the term "other persons involved" leaves the question of whether parents or guardians are to be included when "the originator" is a child-client.

The earlier APA Code of Ethics (1968) made some implied distinctions between the child and the adult

client by referring to "the responsible person." Principle 7, Client Welfare, Section D, stated that

the psychologist who asks that an individual reveal personal information to be divulged to him does so only after making certain that the responsible person is fully aware of the purposes of the interview, testing, or evaluation and of the ways in which the information may be used.

Similarly, Principle 8, Client Relationship, Section B, stated that "when the client is not competent to evaluate the situation (as in the case of a child), the person responsible for the client is informed of the circumstances which may influence the relationship." Thus, as vague as this code was in reference to the psychologist/child-minor relationship, it did imply that the child-client is incapable of comprehending his position and is thus incompetent to consent to treatment or have the same rights as an adult in the psychotherapeutic relationship. It is not surprising, then, that McGuire's (1974) study revealed a general lack of awareness, at least among psychologists, as to the content and applicability of existing APA Code of Ethics to the child in psychotherapy. The current APA Code of Ethics does not even make the implied distinctions of its predecessor.

Rosenberg and Katz (1972) consider legal issues of psychiatric treatment of minors. They present the implications of the law which generally provide that minors,

even mature ones, do not have the right to contract for or undergo psychiatric (or psychological) treatment without the specific permission of parents or guardians. It should be noted that the age of the minor and complexity of treatment may affect what situations the courts would likely favor making an exception to this general principle. These authors point out that the privileged communication statutes fail to establish to whom the privilege belongs in the case of a minor--to the minor or to his parents or guardians. Other authors consider whether it is the parents' or the child's right to waive the privilege (Shah, 1969b; Geiser and Rheingold, 1964).

This dilemma raises the further question of exactly who the client is in psychotherapeutic treatment of a minor. Some authors believe that the parent represents the child-client while others contend that confidentiality is just as essential in therapy with children as with adults.

This diversity of opinion is greatly attributable to the fact that each therapist's "idea of guarding secrets is considerably predetermined not only by his personality structure but also by his professional development" (Lowental, 1974, p. 236). A further complication is the difficulty in defining exactly "Who is a child?" when maturity levels vary so greatly.

In discussing the individual's rights during psychological treatment, Ackley (1974) states that "the services of the psychologist are rendered to a client and belong to the client" and that "the client is the person who has come to the psychologist for professional services, whether he has come on his own initiative or has been referred by another" (p. 21). He continues, however, that "the parent of a minor who is a client has the right of the client" (p. 21). He further maintains that working independently of parents invades the personal rights of both child and parent, the implication apparently being that the child's communications to the counselor are open to the parent.

Slovenko (1966) writes that "child therapy can never be a strictly two person arrangement" (p. 57). He encourages parent involvement in child therapy, specifically noting that "environmental manipulation" may be essential in the treatment of children. Slovenko and Usdin (1961) take a similar position. These authors emphasize the sanctity of confidentiality in the patient/psychiatrist relationship, stating that for the good of the patient "the psychiatrist is indeed forced to keep the patient's confidence" (p. 438). Nonetheless, they make the clear distinction that children (along with the physically handicapped and alcoholics) are exceptions to this

psychotherapeutic approach because others are directly responsible for them.

Within the context of the school system, where the psychotherapeutic relationship exists between student and counselor or school psychologist, Blue (1973) and Goslin (1971) emphasize the importance of obtaining parental consent and only secondarily mention that the consent of the child is sometimes desirable. Along this same line, Trachtman (1973) has clearly stated that he perceives the parent as the client when the child is undergoing counseling at school. He views the school as an instrument for the satisfaction of the parent.

Goldman (1972) likewise derogates the assumption that children or adolescents should be given a confidential counseling relationship because he believes that parents know what is best for their child. Only in cases where the parent is ignorant, disturbed, hostile, or negligent should the counselor supersede the usual parental prerogatives.

Legally and morally parents are responsible for their children, and no professional person . . . has any business placing himself in loco parentis. After all, it is the parent who will have to live with the outcome and will be responsible for what happens thereafter. (pp. 371-372)

McDermott (1974) notes that decisions as to whether or not to inform parents or authorities of facts

or professed facts revealed by the pupil-client are difficult to make. Nonetheless, he writes that it is necessary to inform pupil-clients that the withholding of confidence is not guaranteed. He states that the psychologist has neither the ethical nor legal prerogative to make an absolute confidential agreement, nor does the child have the right to exercise such requests or to give consent. He concludes that parents "possess an unforfeitable right to all pertinent information regarding their children" (p. 29). St. John and Walden (1926) also point out an obligation to give parents of minors "information which will assist them in their parental responsibilities" (p. 683).

Szasz (1967) examines the role of the college psychotherapist, describing him as a double agent with divided loyalties between students (including minor students) and the institution. He contends that college psychiatrists are so willing to break confidences of their patients whenever they personally consider it in the best interest of the patient, the institution or the community, that "any reference to 'confidentiality' is absurd" (p. 18).

The confidentiality of communication of minor-clients has, then, been considered by these various authors as secondary to the priority of informing

parents. Even so, the importance of confidentiality in the psychotherapeutic relationship is undeniable. In fact, it is hard to imagine psychotherapy being carried on in the absence of an atmosphere of confidentiality. This point is emphasized in the ethical standards of psychologists and other professional organizations. Furthermore, a statement by the American Psychiatric Association (1970) describes confidentiality as a bond between therapist and patient which is both "sacred" and "mandatory" (p. 1549).

Geiser and Rheingold (1964) write that:

. . . therapy relations are typically of the most personal, private, and intimate nature, and a person's right to privacy in these vital human relations should be protected. In order to effectively carry on diagnosis and/or therapy, and only these functions, an attitude of privacy and confidentiality is essential. (p. 836)

The issue thus becomes whether it is desirable, even possible, to maintain an attitude of strict privacy and confidentiality with adult clients in therapy but not with child-clients. A number of authors maintain that the minor-client is indeed entitled to confidentiality in psychotherapy. Moreover, some research shows that practitioners do in fact tend to respect the minor's right to confidential communications.

Rosenberg and Katz (1972) note that, "though the law

generally demands that parents have a right to informed consent," it is not always therapeutically desirable to provide details of the causes and nature of treatment. These authors write that limiting the psychotherapeutic treatment of minors "will not further our traditional concern of providing for the protection and welfare of minors" (p. 56).

In an article entitled "The Ethics of Counseling," Wrenn (1952) proposes ethical guidelines which emphasize the importance of confidentiality in the counseling relationship with children.

It has been suggested that the confidential nature of the interview is less to be stressed when the client is a child and that permission to transmit is not necessary for children. I doubt this assumption. A child's trust in a counselor may be betrayed as well as an adult's. A child is very much a person and the integrity of his personality must be protected while at the same time admitting that parents' consent must be obtained for treatment or referral. (p. 172)

In his proposed guidelines, Wrenn suggests that the counselor must obtain his client's permission before communicating any information about the client that has been given in the counseling relationship, even to parents.

Similarly, Hyman and Schreiber (1975) list a number of recommendations in their discussion of child advocacy. Though these authors maintain that the parent should be interviewed and explained his legal rights, they

specifically state that: "Children and adolescents should be provided confidentiality with the exception of the 'future crime limitation' which would include plans to commit any crime, including suicide" (p. 56).

The position statement for psychiatrists warns against "divulging details about the youth's problems to the parents--a practice that can be detrimental to the young person" (American Psychiatric Association, 1970, p. 1546).

In a recent discussion of treatment of adolescent psychiatric inpatients, Corder, Haizlip and Spears (1976) specify that standards of sharing information should be outlined in the treatment contract. They believe parents should be informed only of issues such as the goals and progress in general, but specific details of the therapy session are to be kept confidential unless they pertain to some area of danger to the patient or others.

Ware (1971) also believes that the counselor/minor-client relationship should be confidential. She recognizes, however, that there are often limits to the confidentiality, and these should be spelled out from the beginning. In this way, the counselor avoids the position of feeling forced to violate the youth's confidence. Along this line, Wilkerson (1973) writes that at certain ages and under certain circumstances, the child is unable

to care for or protect himself or make prudent choices in his own best interests. Here the child has a right to "parental responsibility," implying social obligation and accountability of the parent, not the parent's right to dominate the child because of his immaturity.

Within the college or university setting, the psychotherapist often has conflicting roles. Blaine (1964) points out that, although maintaining the private, confidential nature in therapy is a primary responsibility of the therapist, various situations may arise wherein communicating student information to parents or administrators is necessary.

Despite the numerous exhortations on both sides of the issue, few actual studies have been conducted in the area of child-client confidentiality. Those studies available show that counselors and psychologists tend to respect the confidentiality of the minor's communications. As Trachtman (1972) states,

There seems to be some sympathy for the psychologist having discretionary power to withhold confidential verbal communication from parents, even by those who would grant parents complete access to the written record. (p. 41)

McGuire (1974) surveyed forty-five mental health professionals concerning their attitudes and behaviors with regard to practical situations involving confidentiality with children in therapy. These professionals

varied in age, years of experience and degree. It was found that the mental health workers in this sample tended to favor a position wherein child-clients are extended the same rights and privileges regarding confidentiality as adult clients. McGuire writes that this position appears to be basically inconsistent with a strict interpretation of the APA Code of Ethics.

It should be noted that even though the therapists tended to respect the confidentiality of the minor-clients, their responses were quite variant. The author hypothesizes that much of the variance was attributable to lack of agreement among professionals as to how they should behave. Within this sample, some individuals experienced considerable conflict regarding the nature of their relationship with a minor in therapy while others experienced virtually no conflict.

A study by McRae (cited in Clark, 1967) entailed a survey of the attitudes of both counselors and school administrators toward confidentiality with pupil-clients. The results of this study indicate that almost all the counselors (95 percent) and a majority of the administrators (68 percent) agreed that a counselor should treat information obtained in a counseling interview (and the records of such information) as confidential to be discussed with no one except the student in counseling.

Furthermore, the counselors were united in their disagreement (92 percent disagree)--though a majority of administrators were in agreement--regarding the position that a counselor ought to furnish any information obtained in a counseling situation to parents or the principal upon legitimate request. Clark makes a point that the official position of the counseling profession is one of limited confidentiality to minors; that is, when a pupil is a minor with the attendant legal, moral, and other responsibilities on the parent and school, such information must be shared with them in some form or manner. Nonetheless, these counselors did not support the official position, instead taking the position that they should maintain complete confidentiality of information received during counseling.

A recent survey by Eisele (1974) examined the probable behavior of school counselors regarding the disclosure of confidential information. Ten real-life ethical situations were included on a questionnaire to a random sample of current members of the American School Counselor Association. The results of this study reveal that counselors would withhold confidential information to protect their clients' welfare. Two factors leading to the decision to reveal confidential information were: The possibility of harm to someone other than their client

if they remain silent, and the internal pressure from the counselor's own value system, rather than external coercion. Once the decision to reveal or withhold information was made, most counselors felt a strong sense of conviction in the correctness of their decision. Factors having little effect on the counselors' decision were personal and social variables and whether the counselor worked in a state with a privileged communication law.

Curran (1969) conducted a survey of the policies and practices of colleges and universities in the United States and Canada concerning confidentiality in student mental health services. The sample included various types and sizes of schools. The great majority of replies revealed that parents are not routinely informed of counseling, contacts for consultation, or short-term, outpatient, crisis-oriented treatment, though parents are generally notified of emergencies, such as hospitalization or suicide attempts. The majority of schools held this position even when the college students were minors. A few schools who do not notify parents of minors noted that they were uncomfortable about the policy. One large eastern university stated:

We realize that certain legal objections may be raised to our policy of not routinely notifying parents of minors about treatment or referral of their children . . .; however, we feel our present policy is advisable and justifiable. (pp. 1522-1523)

Another school's position was to "put therapeutic considerations first, and let other aspects, including legal ones, come later" (p. 1523).

The results of these four studies reveal a trend among psychologists and counselors to maintain confidentiality in their psychotherapeutic relationships with minor-clients, despite ethical codes and legal standards which dictate welfare of the child to his parents or guardians. It is interesting that the prevailing practice of notification of parents in the treatment of minors for mental illness is just the opposite the procedure generally followed in the treatment of minors for physical illness. In the former case, notification is made only in emergencies, while in the latter case, lack of notification or informed consent in emergencies is legally excused (Slovenko, 1966).

Significantly, the recently proposed revision to the principle concerning confidentiality in the APA Code of Ethics recognizes the importance of confidentiality in the psychologist/child-minor relationship. Section J of the proposed guidelines states:

Where a legal minor is the primary client, the interests of the minor shall be paramount. The child's best interests to do so [sic]. In such cases, psychologists make a serious attempt to obtain the child's consent. ("Proposed to," 1977, p. 84)

Until more definite standards are officially

adopted by mental health professionals, it appears that the therapist will have to use the psychological age or the condition of the client rather than chronological age in determining the approach to be taken in dealing with parents (Slovenko, 1966).

Trachtman (1974) suggests that the psychologist examine each instance of his behavior with an elementary school child, then consider how he might behave differently if the client were a college student. Any differences in behavior must be defensible because the psychologist is clearly differentiating between appropriate behavior with a child and an adult. Trachtman further recommends that the psychologist consider whether the line should be drawn between elementary school and junior or senior high school.

Ladd (1971) suggests drawing formal distinctions between the ways different age groups should be treated. He suggests that those who deal with minors should categorize them as young children (6 to 9), older children (10 to 13), and youths (14 to 17) and should delineate rights and prerogatives for each category. Under such a plan, a 15-year-old's problem may be treated with a confidentiality not appropriate to a 10- or 12-year-old. Ladd writes that such a graded system

. . . would have at least the merit of forcing both parents and professionals to take account of a young person's expanding rights and to realize that . . . the time is coming for him to be . . . entitled to all the rights of adulthood. (p. 268)

Goldman (1972) agrees that children of varying ages have varying degrees of judgement and competence. Nonetheless, he argues that the mental health worker is not in a position to decide whether a particular child is or is not competent to refer himself. He refers to that decision as "a kind of God-playing" which "really has taken the ultimate responsibility away from parents, courts, everyone, and placing it in one's own hands" (p. 373).

On the other hand, Rosenberg and Katz (1972) point out that some minors are capable of acting autonomously and are capable of making decisions about psychotherapy. In considering the rights of children in general, Arthur (1973) writes that the child should be given the freedom to choose between alternatives once he is able to "recognize each alternative, forecast its consequence, and compare the advantages and disadvantages" (p. 137). Without such maturity, however, the child's choice between available alternatives may be needlessly harmful to himself or to others.

The issue thus becomes whether the minor-client is

in fact capable of comprehending his position and is thereby competent to undergo psychotherapeutic treatment with the assurance of confidentiality afforded an adult. The traditional concern of society with the protection and welfare of minors is based on the notion that the minor must be protected against his own innocence and lack of experience. If the therapist can establish the child-client's intellectual ability to contribute to and participate in the psychotherapeutic process, this concern would be unfounded. Moreover, there may exist the possibility that the minor in psychotherapy may need to be protected more against the divulgence of his private communications than his own innocence.

In summary, divergent opinions appear in the literature as to the status of the child in psychotherapy, and ethical standards and legal statutes are vague on the issue. Studies which have examined the attitudes and behaviors of psychologists and counselors have found that practitioners tend to respect the confidential communications of their child-clients. The capacity of the minor to comprehend the nature and consequences of treatment appears crucial in determining the confidential nature of the psychotherapeutic relationship.

In view of such factors, a study of the minor-client's conception of confidentiality in the

psychotherapeutic relationship seems not only relevant but very necessary. It was with such an attitude that a major attempt was made to explore the child's point of view. The intent in this study, then, was to examine the minor-client's conception of confidentiality in psychotherapy. Developmental evolvement of conception of confidentiality as well as variables which might affect this concept were expected to be apparent.

One major hypothesis examined was that older children would have a significantly better understanding of confidentiality than younger children. Moreover, it was expected that some children, particularly younger ones, might understand certain areas of confidentiality but not others.

A second hypothesis was that certain variables could grossly predict the level of the child's understanding of confidentiality in psychotherapy. These variables were:

- (a) whether the child perceives that confidentiality has been adequately or inadequately explained to him/her;
- (b) whether the present counselor is perceived as maintaining or violating confidential communications;
- (c) whether any counselor (previous or present) is perceived as having maintained or violated confidential communication; and
- (d) whether the child approves or disapproves of breaking confidentiality in the interest of

helping self or another. Positive experiences and attitudes were expected to indicate children with better than average understanding of confidentiality, while negative experiences or attitudes were expected to indicate children with below average understanding of confidentiality.

A third hypothesis was that at least some of the following demographic and related variables would be significantly correlated with the child's conception of confidentiality: sex, school-grade level, intellectual level, level of academic functioning as compared to peers, diagnostic impression, referral source, previous therapy, concurrent (group or family) therapy, length of present therapy, sex of counselor and sex of interviewer.

METHOD

Subjects

Thirty-nine children undergoing counseling at the Community Mental Health Center at Orange Regional Medical Center participated in this study. Only outpatients who had had at least two therapy sessions, excluding intake interview, participated.

Within the sample, there were sixteen females and twenty-three males. The children ranged in age from 6 to 15 years old. Three age groups were delineated as follows: (a) 6-8 years; (b) 9-11 years; and (c) 12-15 years. Fourteen subjects were in the first two groups, and eleven subjects were in the latter group. The population from which this sample was taken was largely white, lower-middle class; consequently, only one member of a minority group was included.

The children varied on other factors. The frequency distribution of subjects according to numerous demographic variables is presented in the following tables.

Table 1

Distribution of Subjects According to
Age and Sex

Sex	Age in Years										Total
	6	7	8	9	10	11	12	13	14	15	
Female	1	2	2	2	2	4	1	0	1	1	16
Male	1	8	0	3	2	1	2	2	1	3	23
Total	2	10	2	5	4	5	3	2	2	4	39

Table 2

Distribution of Subjects by Sex of Counselor
and Sex of Interviewer

Sex of Interviewer	Sex of Counselor		Total
	Female	Male	
Female	15	10	25
Male	7	7	14
Total	22	17	39

Table 3

Distribution of Subjects by Previous and
Concurrent Psychotherapy

Concurrent Therapy	<u>Previous Therapy</u>		Total
	No	Yes	
None	16	13	29
Group	2	0	2
Family	5	3	8
Total	23	16	39

Table 4

Distribution of Subjects by Referral Source
and Primary Diagnosis

Primary Diagnosis	Referral Source				Total
	School	Reopen, Self, Family, Friend	Professional	Court	
Organic Brain Syndrome	4	3	0	1	8
Personality Disorder	1	1	0	0	2
Conduct Disorder	8	7	4	0	19
Neurosis	1	2	0	0	3
Psychosis	1	1	0	0	2
Depression	1	1	2	0	4
Other	0	1	0	0	1
Total	16	16	6	1	39

Materials

Materials used were: an interview questionnaire (see Appendix 1) and a brief demographic data sheet (see Appendix 2). The interview questionnaire was designed by the author for the purposes of evaluating the child-client's conception of confidentiality within the psychotherapeutic relationship and finding variables that would predict how well the concept was understood.

The questionnaire demonstrates content validity in that items tap the basic aspects of confidentiality found in the American Psychological Association's Code of Ethics (1977). Five areas of confidentiality were identified using the code, and four questions were designed for each area (see Appendix 3). In this way, the minor-client's understanding of confidentiality was assessed in relation to the ethical standards of confidentiality stipulated for clients of psychologists. That is, the child's concept of confidentiality was examined according to the stipulates for confidentiality for psychologists' clients, regardless of age. The five areas of confidentiality identified from the APA Code of Ethics are as follows:

1. It is the psychologist's responsibility to safeguard information about the client that has been obtained during psychotherapy (Principle 5);
2. information received in confidence should be revealed only when there is clear, imminent danger (Principle 5, Section A);

3. the confidential information is discussed only for professional purposes and only with those clearly concerned with the case (Principle 5, Section B);
4. the confidential information should be released only when the client has given his/her express permission (Principle 5, Section D); and
5. it is the psychologist's responsibility to inform the client of the limits of confidentiality (Principle 5, Section D).

Additionally, four variables were identified which might predict the child's level of understanding of confidentiality. Two questions for each variable were designed to assess whether the child's experience or attitude was positive or negative for each variable (see Appendix 4). These four variables are as follows:

1. Explanation of confidentiality in therapy;
2. experience with current counselor;
3. experience with any counselor (previous or present); and
4. personal attitude toward breaking a secret in the interests of helping self or others.

Other questions besides those designed for assessing the child's conception of confidentiality and predictor variables were included in the questionnaire for the purpose of avoiding boredom, confusion, or suspicion in the child (see Appendix 5).

Reliability of measure was assessed using a split-half procedure. Two questions randomly chosen from each

of the five areas of confidentiality and one question from each of the four predictor variables were included in each half of the questionnaire.

For the entire population of subjects, the measure of internal consistency was $r = .79$. When reliability coefficients were calculated for each of the age groups, differences among groups were apparent. These measures were as follows: (a) age 6-8 years, $r = .74$; (b) age 9-11 years, $r = .72$; and (c) age 12-15 years, $r = .90$.

Procedure

Prior to contact with the child, the counselor presented the parent(s) with a release form (see Appendix 6) to secure permission for the child's participation in this study. To protect the identity of the children, they were each assigned a code number upon first meeting the interviewer. An incidental list of code numbers and names was kept by the interviewer for the length of the study for the sole purpose of matching code numbers with appropriate records necessary to complete the study.

There were two interviewers--one female, one male--to whom the children were randomly assigned as they came in. Upon first entering the interviewing room, a bowl of various miniature candy bars, raisins and gum was pointed out, with the explanation that the child would receive his/her choice of one piece after the interview. The

bowl was then placed on a chair under the table, out of the child's sight.

The children were read the paragraph at the top of the questionnaire in order to explain in general terms the reason for the interview and to establish the understanding that the child's answers were strictly confidential. The child was informed that names were not being used, and it was stressed that neither parents nor counselors would have access to the answers. It was also ascertained at this time whether the child's counselor was male or female, so the questions could be read appropriately.

The child was then interviewed according to the questionnaire. Only oral responses (usually "yes" or "no") were required from the child. Although no specific feedback was given, midway through the questionnaire, the children were told they were about half done and that they had been doing a good job answering questions.

After the interview was complete, the child's file was opened by the interviewer or assistant for the purpose of filling out the demographic data sheet.

Statistical Analyses

Section A. The child's answers to the questions concerning the confidential nature of psychotherapy were scored as either "1" or "0," where "1" indicates an

answer in line with the APA Code of Ethics and "0" does not. As there were twenty scored questions, each child had a total score within the range of 0 to 20.

One-way analyses of variance were performed to find significant differences among age groups using total score and specific confidentiality-area scores as dependent variables.

Section B. Answers to predictor variable questions were scored as either "+" or "-", where a "+" indicates a positive experience or attitude and a "-" indicates a negative experience or attitude. For example, on the variable of experience with current counselor, a "+" indicates the child perceives his present counselor has kept his confidential communications, while a "-" indicates the child perceives his confidential communications as having been violated.

For each predictor variable, only results of children whose scores on both questions for that variable were in the same direction (i.e., "+,+" or "-,-") were used. Each variable, then, had two groups: one with consistently positive experiences or attitudes and one with consistently negative experiences or attitudes.

The two groups for each variable were further separated by the criteria of a total score above the mean of their age group or a score below this mean. A chi-square

analysis was then performed for each variable to determine significant relationships between total scores and answers to predictor variables.

Section C. A number of one-way analyses of variance were performed on the collected demographic data to find significant differences in total and area scores according to the following variables: sex, school-grade level, intellectual level, level of academic functioning as compared to peers, diagnostic impression, referral source, previous therapy, concurrent (group or family) therapy, length of present therapy, sex of counselor and sex of interviewer.

RESULTS

Section A. The distribution of mean confidentiality scores according to age group is shown in Table 5. One-way analysis of variance of the total score means by age groups indicated a significant difference ($F = 3.988$; $df = 2$; $p < .027$). Further analysis (Student-Newman-Keuls) revealed that the scores of the youngest and middle groups were not significantly different; nor were the scores of the middle and oldest groups significantly different. Interestingly, however, the total mean score of the youngest age group was significantly lower than the total mean score of the oldest group ($p < .05$).

Separate one-way analyses of variance across age groups for each area of confidentiality were completed. One-way analysis of variance for area 1 (psychologist responsible for safeguarding information about client) revealed no significant differences among age groups. One-way analysis of variance across age groups did reveal a significant difference for area 2 (confidential information revealed only when clear, imminent danger) ($F = 4.495$; $df = 2$; $p < .018$). Further analysis of this difference (Student-Newman-Keuls) revealed that the middle age group scored significantly higher than the youngest

Table 5

Mean Confidentiality Scores According to
Age Groups of Subjects

Area	Age Group		
	6-8	9-11	12-15
1	3.07	2.71	3.35
2	2.36	3.36	2.44
3	2.93	2.79	3.44
4	2.36	3.00	3.63
5	<u>2.71</u>	<u>2.64</u>	<u>3.54</u>
Total Score	13.43	14.50	16.40

and oldest groups ($p < .05$).

For area 3 (confidential information discussed only for professional purposes) and area 5 (psychologist responsible for explaining limits of confidentiality), one-way analyses of variance across age groups revealed no significant differences. One-way analysis of variance across age groups for area 4 (confidential information released only with client's express permission) did reveal a significant difference ($F = 7.680$; $df = 2$; $p < .002$). Further analysis of this difference (Student-Newman-Keuls) revealed that the youngest group scored significantly lower than the middle or oldest groups ($p < .05$).

Section B. The distribution of subjects according to their scores on the four predictor variables is shown in Table 6.

The data presented in Table 6 show significant findings for two of the four predictor variables. Chi-square analysis was significant for the variables of experience with current counselor ($\chi^2 = 4.057$; $df = 1$; $p < .05$) and experience with any counselor (previous or present) ($\chi^2 = 8.0104$; $df = 1$; $p < .01$). Although the distribution of subjects for the variable of perceived explanation of confidentiality and the variable of attitude toward breaking confidentiality were in the predicted

Table 6

Chi-square Distribution of Subjects
According to Predictor Variables

Variable	Observed Frequency	
	Score $\geq \bar{X}$ of age group	Score $< \bar{X}$ of age group
Confidentiality Explained:		
Adequately	7	6
Inadequately	5	10
$\chi^2=1.199$; $df=1$; $.25 < p < .50$		
Experience with Current Counselor:		
Confidentiality kept	13	11
Confidentiality violated	0	4
$\chi^2=4.043$; $df=1$; $p < .05$		
Experience with Any Counselor:		
Confidentiality kept	19	13
Confidentiality violated	0	7
$\chi^2=8.104$; $df=1$; $p < .01$		
Breaking Confidentiality:		
Approves	6	4
Disapproves	7	10
$\chi^2=0.896$; $df=1$; $.25 < p < .50$		

direction, the chi-square analysis was not significant ($.25 < p < .50$ for both).

Section C. Separate one-way analyses of variance for the variable of sex of the child were completed for the total confidentiality score and the separate area scores. For the total score and areas 1, 2, 3, and 4, no significant differences were revealed. A significant difference for area 5 (psychologist responsible for explaining the limits of confidentiality) was revealed, however ($F = 9.545$; $df = 1$; $p < .004$). Further analysis (Student-Newman-Keuls) revealed that the male subjects scored significantly lower in this area than the female subjects ($p < .05$).

Similarly, separate one-way analyses of variance for the variable of sex of interviewer were completed for the total and area scores. No significant differences were revealed for the total score or areas 1, 3, 4, and 5. For area 2 (confidential information revealed only when clear, imminent danger), however, a significant difference was found ($F = 5.226$; $df = 1$; $p < .027$); further analysis (Student-Newman-Keuls) revealed that the subjects of the female interviewer scored significantly lower in this area than the subjects of the male interviewer ($p < .05$).

For the variable of sex of counselor, separate

one-way analyses of variance for total and area scores revealed no significant differences.

For the variable of length of therapy, the subjects were divided into three groups: 2-10 sessions, 11-25 sessions; and over 25 sessions. Separate one-way analyses of variance across these subject groups for the total and area scores were completed. No significant differences were revealed for the total score or for areas 1, 3, 4, and 5. One-way analysis of variance did reveal a significant difference for area 2 (confidential information revealed only when clear imminent danger) ($F = 5.80$; $df = 2$; $p < .007$). Further analysis (Student-Newman-Keuls) revealed that the group of subjects having over 25 sessions scored significantly lower in this area than the other two groups ($p < .05$).

For the variable of concurrent therapy, the subjects were divided into three groups: no concurrent therapy; group therapy; and concurrent family therapy. Separate one-way analyses of variance across these age groups were completed for the total and area scores. No significant differences were found for the total score or for areas 1, 3, 4, and 5. A significant difference for area 2 (confidential information revealed only when clear, imminent danger) was revealed, however ($F = 2.786$; $df = 3$; $p < .054$). Further analysis (Student-Newman-Keuls)

revealed that subjects in concurrent family therapy scored significantly lower in this area than subjects in the other two groups ($p < .05$).

For the variable of current school-grade level, the children were divided into ten groups; that is, kindergarten through Grade 9. Separate one-way analyses of variance across groups were completed for total scores and area scores. No significant differences were revealed for areas 1, 2, 3, and 5. One-way analysis of variance did reveal a significant difference for the total confidentiality score ($F = 4.234$; $df = 9$; $p < .002$). Further analysis (Student-Newman-Keuls) revealed that the subjects in Grade 9 scored significantly higher than the subjects in Grade 2 ($p < .05$). One-way analysis of variance also revealed a significant difference for area 4 (confidential information released only with client's express permission) ($F = 3.452$; $df = 9$; $p < .006$). Further analysis (Student-Newman-Keuls) revealed that the subjects in Grade 9 and in Grade 5 scored significantly higher than subjects in the other grades ($p < .05$).

Separate one-way analyses of variance for total scores and area scores were completed across subject groups for each of the following variables: previous therapy (no, yes); referral source (school, reopen/self/family/friend, professional, court); intellectual level

(below average, average, above average); and academic level (below grade level, on grade level, above grade level). No significant differences across subject groups were revealed for any of these variables in either total or area scores.

DISCUSSION

Section A. As can readily be discerned from the data, this study generated support for the hypothesis that older children have a significantly better understanding of confidentiality in psychotherapy than younger children. Statistical difference beyond the .05 level revealed that children age 6 to 8 years scored lower on the confidentiality questionnaire than children age 12 to 15 years. Although neither of these groups' scores were significantly different from the scores of children age 9 to 11 years, the total mean scores increased as the age of the children in the groups increased.

Such results can be interpreted to mean that children evolve a conception of confidentiality gradually as they grow older. Very young children may misinterpret some of the basic stipulates of confidentiality in the psychotherapeutic relationship. This conclusion is underscored by the fact that the group of youngest children scored significantly lower than the older group on the specific area concerning confidential information being released only with the client's express permission.

Considering these data, a very important implication for psychotherapists is apparent. The finding that

the child's developmental level is related to his/her conception of confidentiality and his/her conception of the importance of obtaining client permission before releasing information adds credence to the possibility of a graded system of confidentiality for children. Such a graded system, as suggested by Ladd (1971), was discussed previously in this paper.

The finding that the middle group of children (age 9 to 11 years) scored significantly higher than the other groups on the area concerning revealing confidential information only when there is clear, imminent danger is an interesting one. One explanation is that there were two different reasons for the low scores of the two different groups. It is possible that the younger children simply did not fully understand the concepts of this area. While the older children did understand what was involved, they did not agree that confidentiality should be broken even when danger was evident. This explanation is supported by the observation that in answering these questions, several of the older children specifically told the interviewers that their secrets should not be told for any reason unless their permission was first asked. This is consistent with attitudes of independence (and sometimes suspiciousness of adults) typically seen in early teen-age children. Apparently then, while the middle group of

children's answers in this area conformed more to the APA Code of Ethics, the older children tended to be more protective of their right to confidentiality and thus scored lower in this area.

The implications for practicing psychologists is again that children in therapy may have to be dealt with differently, depending on age. Older children in particular may require a more thorough explanation of the limits of confidentiality and the conditions under which confidentiality might be broken. Admittedly, this may be a difficult step in that excessive defensiveness could be aroused which may in turn impede the flow of communication in therapy. On the other hand, were a situation to occur that necessitated breaking a confidence and the child had not been forewarned of such a possibility, the effect on future therapy may be devastating. Thus, the benefits of explaining in detail the limits of confidentiality seem to outweigh the potential difficulties.

Section B. Results of this section emphasize the importance of an atmosphere of trust in the psychotherapeutic relationship. Of the four predictor variables, the two which were significantly related to total confidentiality scores both explored the child's perception of whether confidentiality had been maintained or violated. That is, a significantly large number of children who

perceived that their confidentiality had been violated scored low. This was found for both the variable of experience with current counselor ($p < .05$) and experience with any counselor, previous or present ($p < .005$).

From a practical standpoint, the implication is that the psychotherapist must be especially aware of the way his/her actions may affect the child's view of confidentiality and, consequently, the progress of therapy. One approach to such awareness is to discuss the issue with the minor-client from time to time as part of the therapy process. It is important to recognize that some children may perceive certain actions as violations of confidentiality while the counselor (or even other children in the same situation) may not. It should thus be stressed that the essential factor is how the child perceives the action--not the counselor or an objective observer.

Furthermore, when dealing with a new minor-client, it may be essential to thoroughly explore his/her perception of previous counseling experience, particularly maintenance or violation of confidentiality.

Lack of support for the first predictor variable apparently indicates that whether or not children believe confidentiality has been adequately explained to them does not significantly affect their actual conception of confidentiality. Integrating the previously discussed results,

one important conclusion is evident: verbal explanations of confidentiality are not as important to children as real-life experiences with it. This is not to say that the strategy of explanation of confidentiality to minor-clients is unnecessary, but rather that the explanation should be reinforced by the counselor's actions.

Support for the last predictor variable was also lacking. Whether children believe that a secret should be broken in the interests of helping themselves or another apparently has little to do with their overall understanding of confidentiality in psychotherapy. Conceivably, such a variable may be related to certain aspects of confidentiality (such as breaking confidentiality in an emergency), but such specific relationships were not explored in this study. It is also possible that the questions designed for this variable (i.e., "Do you think it would be OK for someone to break a secret if they cared about you and thought they were helping you?") were somewhat ambiguous and were perceived by the children as measures of basic interpersonal trust without regard to the circumstances.

Section C. Some demographic variables were found to be significantly related to confidentiality scores on the questionnaire, yet most of the relationships involved specific areas rather than total scores.

On the variable of sex of the child, it was found that male subjects scored significantly lower than female subjects in the area concerning the psychologist's responsibility to explain the limits of confidentiality. As no significant differences were found between total confidentiality scores for males and females, one might be led to believe that female children simply interpreted this responsibility as part of their counselor's job while boys were less concerned with this aspect. Another possible explanation may be that female children more than male children look for verbal assurances and explanations during psychotherapy.

Three separate variables showed significant differences between subject groups in the area of confidentiality which explored the revealing of confidential information only when there is clear, imminent danger. More specifically, in this one area, the following results were found: children in therapy over 25 sessions scored significantly lower than children in therapy lesser lengths of time; children in concurrent family therapy scored significantly lower than children in concurrent group therapy or no concurrent therapy; and subjects of the female interviewer scored significantly lower than the subjects of the male interviewer. Because of the diversity of groups scoring significantly low in this area, closer examination of the questions involved appears

warranted.

The four questions of this area appear to explore the child's willingness to follow the counselor's judgment as to what is an emergency or what is in the child's best interests. One question, for example, asks "Suppose (pretend) your counselor thought there was an emergency and that telling another person what you said would help you best. Do you think he/she should tell the person?"

Somewhat surprisingly, then, two of the groups who appeared least willing to follow their counselor's judgment were children who had been in therapy the longest and children who were in concurrent family therapy. These results can be interpreted in a variety of ways. One explanation is that these are the children who are struggling the hardest with attempts at independence and hence they would be most reluctant to let the counselor make decisions for them. A different explanation is that these children are more resistive to psychotherapy in general (which is in fact why they have required prolonged or family therapy). Alternatively, the possibility exists that whatever problems resulted in the need for prolonged or family therapy also interfered with the establishment of trust in the counselor's judgement. Whatever the proported explanations, it is an interesting phenomenon, and one which requires further study.

The finding that subjects of the female interviewer scored significantly lower than the subjects of the male interviewer in this one area only is difficult to explain. Subtle personality characteristics may account for this, of course. As the questions in this area were some of the longest in the questionnaire, it is also likely that the questions were read less effectively by one interviewer which in turn affected the children's responses (though it is impossible to say in which direction).

On the variable of school-grade level, some significant differences were found for the total and area 4 scores. These results appear inconclusive, however, as the number of subjects in groups varied greatly and in some cases was quite small. (Two groups had only one subject while one group had nine subjects.) It appears inappropriate, then, to make interpretations about the significant differences found here; suffice it to say that further research is needed in this area.

Suggestions for Future Research

1. It appears most appropriate at this point to examine the adult-client's conception of confidentiality in comparison to the child's. If identical questions were used for adults and children, then comparison of the scores between adults and various-age children may give further insight into the child's involvement of the

concept of confidentiality.

2. It would also be informative to have the counselor answer the confidentiality questions as he/she believes the child should perceive the psychotherapy experience. Comparison of counselor and child-client results may distinguish areas of misunderstanding of which the counselor was previously unaware.

3. Similarly, parents could complete the questionnaire as they believe their child perceives the psychotherapy experience or as they themselves perceive the experience. These scores could in turn be compared to the scores of the therapist and/or the children. Such studies may have important implications for the therapist/child-client relationship; they may further give insight into the role of the parent when the client is a minor.

4. For children who perceive that their confidentiality has been violated by a counselor, further exploration of this experience may be warranted. It would be especially enlightening to contrast the child's view of a violation of confidentiality with the counselor's.

5. As school-grade level is dependent upon other factors (most notably age as well as academic achievement and intellectual level), it seems appropriate to replicate this study with a larger number of children in each grade level. Similarly, another study could be conducted

in which larger samples of children in concurrent therapies could be included. Results of such studies may clarify some of the results of this study.

6. It is possible that some populations of children may have conceptions of confidentiality quite different from the children in this sample. It should be recognized that subjects in this study were out-patients (largely white, lower-middle class) whose participation was strictly voluntary. Thus, replication studies using different populations of children (such as hospital in-patients, minority groups, children in group homes, children in school counseling) appear most appropriate.

CONCLUSION

Studies by other investigators which have explored the issue of confidentiality in psychotherapy have not examined the child's viewpoint. The current study attempted to explore the child's conception of confidentiality as well as variables which might affect this concept.

Results of this study indicate that children gradually evolve a concept of confidentiality that is consistent with professional guidelines for confidentiality with adults in therapy. Results also emphasize the importance of having the child perceive that his confidentiality has been maintained by the psychotherapist.

Such results, which suggest that minor-clients may vary in their understanding of confidentiality according to age, may have important implications for the revision of professional ethical guidelines. These ethical codes may well need to be made more specific regarding the status of children in therapy. First, it is possible that a graded system (such as suggested by Ladd, 1971) could be adopted. Under such a system, children in a younger age group may not be afforded the same confidentiality as children in an older group. Second, the codes could

specify more clearly the conditions under which the communications of the child-client will be afforded the same confidentiality as the adult-client and the conditions under which they will not. Explaining such conditions appears especially important for older children. Third, the role of the parents or guardians and their access to the child's communications should be clarified. Again, the role of the parent or guardian may differ according to age of the child.

APPENDIX 1: QUESTIONNAIRE

QUESTIONNAIRE

Code #: _____

Sex of Counselor _____

Sex of Interviewer _____

I'm going to ask you some questions about school and your counselor and what you think some people are supposed to do. Most of the questions you can just answer yes or no. Some of the questions may sound alike, but just answer them anyway. If you don't understand a question, I'll repeat it.

Try your best to answer everything honestly. Your name is not on the answers so no one will know which answers are yours. Your counselor and your parents will not see your answers.

- - - - -

YES NO

What does "keeping a secret" mean to you?

(Assess child's understanding of concept.
Must be able to adequately demonstrate
understanding to continue questionnaire.)

X X

Examples of acceptable definitions:

It's private and no one else should know.
The person won't tell anybody what you
told him not to.
I won't tell anybody what you said.
You trust someone not to tell what you've
told them.

What is your counselor's job? _____

- (1) 1. Is it part of your counselor's job to
keep things secret that you ask him/
her to?

1 0

Is it part of your teacher's job to
give you homework?

X

		YES	NO
(4)	2. Should your counselor get your permission before he/she tells another person something you told him/her?	1	0
	Is it part of your job at home to keep your room clean?	X	
(3)	3. Do you think your counselor is supposed to talk to his/her friends about the things you tell him/her in secret?	0	1
	Do you think school should be fun?	X	
(A)	4. Has anyone ever explained to you that what you say in counseling will be kept secret?	+	-
	Have you ever fallen asleep while you were watching T.V.?	X	
(2)	5. Suppose (pretend) your counselor thought there was an emergency and that telling another person what you said would help you best. Do you think he/she should tell the person?	1	0
	If your teacher really cares about you, is it OK if she gives you hard work?	X	
(5)	6. Is your counselor supposed to tell you what things he/she cannot keep secret from other people?	1	0
	Do you think you should come here more often?	X	
(1)	7. Do you think your counselor keeps your secrets as well as he/she would keep a grown-up's secrets?	1	0
	Is your father supposed to help do work around the house?	X	
(B)	8. Has your counselor here ever told someone a secret you asked him/her not to?	-	+
	Has your mother ever made you do something you didn't want to do?	X	

	YES	NO
(3) 9. Is it part of your counselor's job to keep your secrets from other people, like your parents?	1	0
Is it part of your teacher's job to help you solve problems?	X	
(2) 10. If you told your counselor something you were going to do to <u>hurt</u> someone else, do you think he/she is supposed to keep that a secret?	0	1
Is it part of your teacher's job to help you get good grades?	X	
(D) 11. Do you think it would be OK for someone to break a secret if they cared about you and thought they were helping you?	+	-
Do you think homework should be easy?	X	
(5) 12. Suppose (pretend) your counselor has to tell your parents certain kinds of things. Should he/she let you know first so you can keep some secrets to yourself?	1	0
If your teacher thought you were being bad, should she make you do extra work?	X	
(4) 13. If your parents wanted your counselor to tell your teacher something but you didn't want him/her to, do you think he/she is supposed to do it anyway?	0	1
Do you think people at this place really want to help you?	X	
(C) 14. Have you ever had a counselor who did not keep a secret you asked him or her to?	-	+
If you like the programs, is it OK to watch T.V. all day?	X	

	YES	NO
(2) 15. If you told your counselor something just a little bad that you did, do you think he/she is supposed to keep that a secret?	1	0
If one person in the class is bad, should your teacher punish everyone?	X	
(5) 16. Should your counselor tell you whether or not he/she can keep your secrets before you talk to him/her?	1	0
Are your parents supposed to help you with your homework?	X	
(3) 17. Do you think your counselor is supposed to tell other people what you said in counseling if they ask him/her?	0	1
If you do an extra job on something, should you get extra money for it?	X	
(A) 18. Have you ever been told how much of what you tell your counselor will be kept secret?	+	-
Do you think it's OK to steal little things once in a while?	X	
(1) 19. Are you sometimes afraid to tell some things to your counselor because he/she may not keep them secret?	0	1
Do you think you should be able to talk in the lunchroom at school?	X	
(4) 20. If you didn't want other people to know about what you said in counseling, do you think your counselor would tell them anyway?	0	1
If someone hits you first, is it OK to hit them back?	X	

	YES	NO
(B) 21. Do you think your counselor here has kept all your secrets to himself/herself?	+	-
Do you think you should be able to stay up later than your parents let you?	X	
(3) 22. Should your counselor make sure your parents know the things you tell him/her just because they want to know?	0	1
Should your teacher make you go to P.E. even if you don't like it?	X	
(1) 23. Is your counselor supposed to talk with you about things you don't want anyone else to know about?	1	0
Is your teacher supposed to make school work as hard as she can?	X	
(5) 24. Should your counselor let you know if some things you say cannot be kept secret?	1	0
Is it part of your job to help clean up the house?	X	
(D) 25. Would you break someone else's secret if you thought you were helping him or her?	+	-
Is it OK to fight with your brothers or sisters sometimes?	X	
(2) 26. If he/she really thinks he/she is helping you to stay out of trouble, is it OK for your counselor to tell your parents what you tell him/her?	1	0
Should people cheat on a test if it is too hard for them?	X	
(4) 27. If your parents ask your counselor what you talked about, should he/she tell them if you don't want him/her to?	0	1
If you asked a friend to help you do some work, do you think he or she would?	X	

YES NO

(C) 28. Have you ever had a secret broken by a counselor before?

- +

Have you ever had to answer questions like this before?

X

Total Score: _____

(1) _____

(2) _____

(3) _____

(4) _____

(5) _____

(A) _____

(B) _____

(C) _____

(D) _____

APPENDIX 2: DEMOGRAPHIC DATA SHEET

DEMOGRAPHIC DATA SHEET

Code Number: _____

Sex of Interviewer: _____

Age: _____

Grade: _____

Sex: _____

Race: _____

Sex of Counselor: _____

Length of Present Therapy: _____
(i.e., number of sessions)Previous Therapy? _____
Age(s): _____

Referral source:

_____ School
_____ Reopen, self, family, friend
_____ Professional
_____ Court
_____ Other

Diagnostic Impression:

_____ Organic Brain Syndrome
_____ Personality Disorder
_____ Conduct Disorder
_____ Neurosis
_____ Psychosis
_____ Other (Specify) _____

Intellectual Level:

Instrument used or impression: _____

_____ Below average or Dull Normal (IQ: below 85)
_____ Average or Normal Range (IQ: 85 to 115)
_____ Above average or Bright Normal (IQ: above 115)

Academic/achievement Level: _____

Instrument used: _____

Presently in concurrent group therapy?

_____ no
_____ group
_____ family

APPENDIX 3: QUESTIONS BY AREA OF CONFIDENTIALITY

APPENDIX 3

QUESTIONS BY AREA OF CONFIDENTIALITY

	YES	NO
<u>Area 1</u>		
The psychologist's responsibility to safeguard information:		
1. Is it part of your counselor's job to keep things secret that you ask him/her to?	1	0
2. Is your counselor supposed to talk with you about things you don't want anyone else to know about?	1	0
3. Are you sometimes afraid to tell some things to your counselor because he/she may not keep them secret?	0	1
4. Do you think your counselor keeps your secrets as well as he/she would keep a grown-up's secrets?	1	0
<u>Area 2</u>		
Information revealed only when clear, imminent danger:		
1. If you told your counselor something you were going to do to <u>hurt</u> someone else, do you think he/she is supposed to keep that a secret?	0	1
2. Suppose (pretend) your counselor thought there was an emergency and that telling another person what you said would help you best. Do you think he/she should tell the person?	1	0
3. If you told your counselor something just a little bad you did, do you think he/she is supposed to keep that a secret?	1	0
4. If he/she really thinks he/she is helping you to stay out of trouble, is it OK for your counselor to tell your parents what you tell him/her?	1	0

YES NO

Area 3

Information discussed only for professional purposes:

- | | | |
|--|---|---|
| 1. Is it part of your counselor's job to keep your secrets from other people, like your parents? | 1 | 0 |
| 2. Do you think your counselor is supposed to talk to his/her friends about the things you tell him/her in secret? | 0 | 1 |
| 3. Do you think your counselor is supposed to tell other people what you said in counseling if they ask him/her? | 0 | 1 |
| 4. Should your counselor make sure your parents know the things you tell him/her just because they want to know? | 0 | 1 |

Area 4

Necessity of obtaining client's express permission:

- | | | |
|--|---|---|
| 1. If your parents ask your counselor what you talked about, should he/she tell them if you don't want him/her to? | 0 | 1 |
| 2. Should your counselor get your permission before he/she tells someone else something you told him/her? | 1 | 0 |
| 3. If your parents wanted your counselor to tell your teacher something but you didn't want him/her to, do you think he/she is supposed to do it anyway? | 0 | 1 |
| 4. If you didn't want other people to know about what you said in counseling, do you think your counselor would tell them anyway? | 0 | 1 |

Area 5

The psychologist's responsibility to explain limits of confidentiality:

	YES	NO
1. Is your counselor supposed to tell you what things he cannot keep secret from other people?	1	0
2. Should your counselor tell you whether or not he/she can keep your secrets before you talk to him/her?	1	0
3. Suppose (pretend) your counselor has to tell your parents certain kinds of things. Should he/she let you know that first so you can keep some secrets to yourself?	1	0
4. Should your counselor let you know if some things you say cannot be kept secret?	1	0

APPENDIX 4: PREDICTOR VARIABLES

APPENDIX 4

PREDICTOR VARIABLES

	YES	NO
(A) <u>Explanation of Confidentiality:</u>		
1. Has anyone ever explained to you that what you say in counseling will be kept secret?	+	-
2. Have you ever been told how much of what you tell your counselor will be kept secret?	+	-
(B) <u>Experience with Current Counselor:</u>		
1. Has your counselor here ever told someone a secret you asked him/her not to?	-	+
2. Do you think your counselor here has kept all your secrets to himself/herself?	+	-
(C) <u>Experience with Any Counselor:</u>		
1. Have you ever had a counselor who did not keep a secret you asked him or her to?	-	+
2. Have you ever had a secret broken by a counselor before?	-	+
(D) <u>Attitude Toward Breaking Secret:</u>		
1. Do you think it would be OK for someone to break a secret if they cared about you and thought they were helping you?	+	-
2. Would you break someone else's secret if you thought you were helping him or her?	+	-

APPENDIX 5: BLIND QUESTIONS

APPENDIX 5

BLIND QUESTIONS

Is it part of your teacher's job to give you homework?

Is it part of your job at home to keep your room clean?

Do you think school should be fun?

Have you ever fallen asleep while you were watching T.V.?

If your teacher really cares about you, is it OK if she gives you hard work?

Do you think you should come here more often?

Is your father supposed to help do work around the house?

Has your mother ever made you do something you didn't want to do?

Is it part of your teacher's job to help you solve problems?

Is it part of your teacher's job to help you get good grades?

Do you think homework should be easy?

If your teacher thought you were being bad, should she make you do extra work?

Do you think people at this place really want to help you?

If you like the programs, is it OK to watch T.V. all day?

If one person in the class is bad, should your teacher punish everyone?

Are your parents supposed to help you with your homework?

If you do an extra good job on something, should you get extra money for it?

Do you think it's OK to steal little things once in a while?

Do you think you should be able to talk in the lunchroom at school?

If someone hits you first, is it OK to hit them back?

Do you think you should be able to stay up later than your parents let you?

Should your teacher make you go to P.E. even if you don't like it?

Is your teacher supposed to make school work as hard as she can?

Is it part of your job to help clean up the house?

Is it OK to fight with your brothers or sisters sometimes?

Should people cheat on a test if it is too hard for them?

If you asked a friend to help you do something, do you think he or she would?

Have you ever had to answer questions like this before?

APPENDIX 6: RELEASE FORM

RELEASE FORM

Florida Technological University
Department of Psychology

PARTICIPATION IN RESEARCH STUDY

INFORMATION:

A research study concerning children's perception of the confidential relationship between child and counselor is being conducted at the Mental Health Center at Orange Regional Medical Center.

The study will entail interviewing a number of children to find their opinions and expectations of confidentiality in counseling. The results should be of great value in understanding the child's concept of confidentiality and how the counseling experience might be improved.

At all times, the identity of the child will be carefully protected. Each child will be assigned a code number so that identification of names will not be necessary. An independent assistant will fill out a brief background sheet on the child using only his/her code number (no names). Information on this sheet will include: age, sex, race, school grade, referral source, diagnostic impression, previous counseling, and intellectual and/or academic level.

It should be made clear that participation or nonparticipation in this study does not affect your child's status at the Mental Health Center in any way. We sincerely hope your child will be able to participate in this project.

CONSENT:

I give my permission for my child to participate in this study. It is hereby acknowledged that the interviewing of my child is for the purpose of a research study only.

Signature

Date

APPENDIX 7: ALTERNATE STATISTICAL ANALYSIS OF
PREDICTOR VARIABLES

APPENDIX 7

ALTERNATE STATISTICAL ANALYSIS OF PREDICTOR VARIABLES

Upon reviewing the results of Section B, it became apparent that, although the chi-square analyses revealed significant differences for two predictor variables, the distribution of subjects was quite uneven in the two groups compared. That is, almost all children perceived that their confidentiality had been maintained while very few perceived that it had been violated. Thus, further analysis of the data appeared warranted in order to clarify the findings associated with the predictor variables.

Statistical analyses. For each predictor variable, the children were divided into three groups: (a) positive responses to both questions ("+,+"), (b) negative responses to both questions ("-,-"); and (c) inconsistent responses ("+,-" or "-,+"). Separate one-way analyses of variance were performed for each variable to find significant differences among the three groups using the total score as the dependent variable.

Results. The distribution of mean total confidentiality scores according to responses to predictor variables is shown in Table 7. Consistent with previous results, one-way analyses of variance revealed no significant differences among the groups for the predictor variables of perceived adequacy of explanation of

confidentiality and attitude toward breaking a secret.

Somewhat surprising, however, was the finding that one-way analysis of variance for the other two predictor variables (both involving perceived maintenance/violation of confidentiality) revealed no significant differences among the groups as far as total score. Even so, it should be noted that the mean scores presented in Table 7 suggest a certain trend for the predictor variables. That is, as the responses to these items became more positive (indicating more positive experiences and attitudes), the mean total scores increased. Although this trend was seen across all variables, it was not found to be statistically significant for any.

Discussion. Apparently, the widely uneven distribution of subjects in the two categories (perceived confidentiality maintained and perceived confidentiality violated) greatly effected the chi-square analysis results. As one-way analysis of variance revealed no significant differences, it is highly possible that the significant differences found with the chi-square analysis resulted from this uneven distribution of subjects rather than actual discriminatory power of the predictor variable questions.

This new analysis of the data does not imply that the counselor's actions are irrelevant as far as the child's

conception of confidentiality. Rather, the new statistical analysis simply could not support the opposite hypothesis because so few children were in the category that perceived that their confidentiality had been violated. Thus, a replication study involving approximately equivalent numbers of children who do and do not perceive that their confidentiality has been maintained appears most appropriate.

Table 7

Mean Total Confidentiality Scores According to
Responses to Predictor Variables

Predictor Variable	Response		
	"-,-"	"+,-" "-,+"	"+,+"
Adequacy of Explanation	13.47	15.75	14.91
Maintenance of Confidentiality by Present Counselor	12.50	14.88	14.80
Maintenance of Confidentiality by Any Counselor	13.00	14.97	--
Attitude Toward Breaking a Secret	13.76	15.90	14.82

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